

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12982

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

13025

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OXFORD		c. LENGTH OF STAY IN 1b X OXFORD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HI-WAY		d. STREET ADDRESS X OXFORD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ERNEST BENJAMIN BANKS		4. DATE OF DEATH Month NOV Day 13 Year 19 59	
5. SEX MALE	6. COLOR OR RACE COL	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 3, 1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ERNEST BANKS SR.		14. MOTHER'S MAIDEN NAME STELLA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-01-6390	
17. INFORMANT ROBERT BANKS		Address OXFORD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED VISCUS 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AUTO ACCIDENT DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DRIVER OF CAR IN COLLISION WITH ANOTHER	
20c. TIME OF INJURY Month, Day, Year 11-13-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIWAY TO		20f. (City or town) (County) (State) NR OXFORD TALBOT MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Louis M. Welch</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WELCH		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-18-59	
22c. NAME OF CEMETERY OR CREMATORY OXFORD CEN.		22d. LOCATION (City, town, or county) (State) OXFORD, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE JAMES B. DASHIELDS		24a. REC'D BY REGISTRAR DATE NOV 19 '59	
ADDRESS EASTON, MD.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HOSPITAL

13082

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13082

1

1. NAME OF DECEASED: []
2. SEX: []
3. AGE: []
4. DATE OF BIRTH: []
5. PLACE OF BIRTH: []
6. OCCUPATION: []
7. CAUSE OF DEATH: []
8. MANNER OF DEATH: []
9. SIGNATURE OF EXAMINER: []
10. DATE: []

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

6:40 AM
RC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>Chris. 30 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Sucessana</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> 17X-2 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Edward</u> Last <u>Banks</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10 1921</u> 38 yrs.
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <u>Tandy Banks</u>	
14. MOTHER'S MAIDEN NAME <u>Gertrude Jones</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>221-14-7978</u>		17. INFORMANT <u>SARAH Banks, Easton, md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Will Follow</u> 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Gun shot wound Abdomen</u> (c) <u>981X</u> DUE TO stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Argument was shot</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11 PM 11-13-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>Centreville GA Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Roseville, Cem.</u>
22d. LOCATION (City, town, or county) (State) <u>Centreville, md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Dashiell</u> ADDRESS <u>Easton, md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

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DATE SIGNED
11-14-59

CERTIFICATE OF DEATH

12984

Reg. Dist. No.

12998

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>23 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>E</u> Last <u>Bilbrough</u>				4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 13/1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Shockley</u>				14. MOTHER'S MAIDEN NAME <u>Catherine DEAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Charles Bilbrough Greensboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH <u>22 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I attended the deceased from <u>11-8</u> , 19 <u>59</u> , to <u>11-30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-30</u> , 19 <u>59</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>11-30-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>202 Dover St.</u>		PHYSICIAN'S NAME (Type) <u>Easton, Md.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-3-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Boulaie, Greensboro, Md.</u>			ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12999

CERTIFICATE OF DEATH

12985

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 1437-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Hiram Middle Biscoe Last Biscoe		4. DATE OF DEATH Month Nov Day 4 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 29, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Biscoe		14. MOTHER'S MAIDEN NAME Martha Nicholson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-36-6394	
17. INFORMANT Thomas Biscoe, son - Chestertown Mo.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary gangrene 163X DUE TO Carcinoma of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 7 A.M. , and that death occurred at 7 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. H. Schmidt M.D.		DATE SIGNED 2195 Washington St. 4th Nov 59	
PHYSICIAN'S NAME (Type) E. C. H. Schmidt		ADDRESS (Street, city or town, state) Chestertown 16, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/7/59	22c. NAME OF CEMETERY OR CREMATORY Sadler'sville	22d. LOCATION (City, town, or county) (State) Sadler'sville Md
23. FUNERAL DIRECTOR'S SIGNATURE Edgar J. Lane ADDRESS Chesapeake Hill, Md		24a. REC'D BY REGISTRAR NOV 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film G252 11-23-59 et

CERTIFICATE OF DEATH

12986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100 Hammond St.</u>		d. STREET ADDRESS <u>100 Hammond St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Blackson</u> Last <u></u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June Unknown</u>
9. AGE (In years last birthday) <u>81?</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Miller</u>		14. MOTHER'S MAIDEN NAME <u>LARUA Biquel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Clifford Blackston, Easton, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Myocardial Infarction</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Prominent</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Hour a. m. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/7</u> , 19 <u>59</u> , to <u>11/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/7</u> , 19 <u>59</u> , and that death occurred at <u>20:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. J. Eglseder M.D.</u>		ADDRESS (Street, city or town, state) <u>12 N. HANSON ST</u> DATE SIGNED <u>11/10/59</u>	
PHYSICIAN'S NAME (Type) <u>L. J. Eglseder M.D.</u>		<u>EASTON MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Lohr, Easton, Md.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>NOV 19 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13026

CERTIFICATE OF DEATH

Reg. Dist. No.

12987

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairbank, Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Fairbank	
3. NAME OF DECEASED (Type or print) WILLIAM R. BROWN		4. DATE OF DEATH November 26, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1873
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done in most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Trappe, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Laura Kapisak, Fairbank, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chances of Tumor DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 26, 1959 to Nov 26, 1959 , that I last saw the deceased alive on Nov 26, 1959 , and that death occurred at 4 p.m. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Guy M. Reeser, Sr. M.D.		ADDRESS (Street, city or town, state) Tilghman, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) GUY M. REESER, SR., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY Tilghman Cemetery		22d. LOCATION (City, town, or county) (State) Tilghman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sh. Hamilton Harrison, St. Michaels, Md.		24a. REC'D BY REGISTRAR DEC 1 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12988

13001

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>minutes</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>712 S. Hanover</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Claresa M. Bryan</u>		4. DATE OF DEATH <u>13</u> Month <u>30</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/4/10</u> 9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Annie White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-744</u> 17. INFORMANT <u>May Marshall Cambridge</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis M. Kelly</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. E. L. T. V.</u>		DATE SIGNED <u>12-1-59</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Shill</u> ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

CERTIFICATE OF DEATH

12989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>309 Gay St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>L</u> Last <u>Bunney</u>		4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>9</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Leta Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Robert H. Bunney, Denton, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>1959</u> , to <u>1959</u> , that I last saw the deceased alive on <u>11/9/59</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>219 S Washington St. 406159</u> DATE SIGNED <u>Nov 16, 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		<u>Denton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u>	22d. LOCATION (City, town, or county) (State) <u>DENTON Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Moore</u> ADDRESS <u>San Denton</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Prange</u>

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3002

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF BIRTH [Faint text, possibly "New York, N.Y."]	
MARITAL STATUS [Faint text, possibly "Married"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "10/25/1955"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. Smith"]		SIGNATURE OF CORONER [Faint text, possibly "A. Jones"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	
SIGNATURE OF WITNESS [Faint text, possibly "Mary Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eggs Eaaton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) 605 Dover st.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harriett Middle Burton Last 				4. DATE OF DEATH Month 11 Day 18 Year 1959			
5. SEX F		6. COLOR OR RACE Col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1892	
9. AGE (In years, last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FACTORY LABOR	
10b. KIND OF BUSINESS OR INDUSTRY Fish Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Randolph				14. MOTHER'S MAIDEN NAME Katherine Pinckney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 		17. INFORMANT Mary Thomas		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Hypertensive Arteriosclerosis DUE TO (c) Cardiac Vascular Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 1/30 , 19 59 , to 11/18 , 19 59 , that I last saw the deceased alive on 11/13 , 19 59 , and that death occurred at 1 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12 N. HANSON ST DATE SIGNED 							
ACTUAL SIGNATURE L. J. Eglender M.D.				DATE SIGNED 12 N. HANSON ST			
PHYSICIAN'S NAME (Type) Ludwig J. Eglender MD				EASTON, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/59		22c. NAME OF CEMETERY OR CREMATORY Richards Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Shiel, Easton, Md.				24a. REC'D BY REGISTRAR DATE DEC 17 '59		24b. REGISTRAR'S SIGNATURE Cedric S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12990

13004

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN IB <u>16 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Copper</u> Last <u>Copper</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>3</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip Mooney</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Copper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>daughter -</u>	
17. INFORMANT <u>daughter -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465x</u> DUE TO <u>Pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis left leg</u> (c) <u>Post-sigmoid abscess</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Patrolman</u> , 19 <u>11:05 P</u> , to <u>4:00 P</u> , that I last saw the deceased alive on <u>11:05 P</u> , and that death occurred at <u>11:05 P</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. West 117th St. Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>4/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Roebuck</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE NOV 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kears</u>	

13005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		d. STREET ADDRESS Near Johns	
3. NAME OF DECEASED (Type or print) First Riley Middle Charles Last Dodson		4. DATE OF DEATH Month Nov Day 10 Year 1959	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1895
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Dodson		14. MOTHER'S MAIDEN NAME JANE Jenkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-05-7364	
17. INFORMANT Ruth D. Hubbard, Hurlock, Maryland, RFD#1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma pancreas DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 27, 1959 , to Nov 11/10, 1959 , that I last saw the deceased alive on 11/10, 1959 , and that death occurred at 12:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. H. P. Barnett M.D.		ADDRESS (Street, city or town, state) Easton Md DATE SIGNED 11/17/59	
PHYSICIAN'S NAME (Type) J. H. P. BARNETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 14, 1959	22c. NAME OF CEMETERY OR CREMATORY Johns Cemetery	22d. LOCATION (City, town, or county) (State) Near Preston, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton ADDRESS Ed. Son, Federalburg, Maryland		24a. REC'D BY REGISTRAR NOV 19 '59 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>				c. LENGTH OF STAY IN 1b <u>5 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Tilghman</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Alice H. Frampton</u>				4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-8-1895</u>	
9. AGE (In years lost birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Isaac A. Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Lowery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-28-5217</u>		17. INFORMANT <u>Veril S. Frampton Tilghman Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>acute infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gradual infarction</u> (c) <u>gradual infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery disease 5 yrs</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>59</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 7</u> , 19 <u>59</u> to <u>Nov 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 7</u> , 19 <u>59</u> , and that death occurred at <u>1:45 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>GUY M REESER, Sr.</u> M.D.				ADDRESS (Street, city or town, state) <u>TILGHMAN Md</u>			
PHYSICIAN'S NAME (Type) <u>GUY M REESER, Sr.</u>				DATE SIGNED <u>Nov 18 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov 10, 59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Leeds Moore Tilghman Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Catharine S. Kraw</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13006

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dover & Harrison Sts.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BEULAH BERKSHIRE GUNTHER				4. DATE OF DEATH Month Day Year Nov. 2, 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1875	
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Kirtley Yowell Berkshire				14. MOTHER'S MAIDEN NAME Emma Allan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Frank Gunther Address Easton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 HRS. YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July , 19 57 , to Nov. 2 , 19 59 , that I last saw the deceased alive on Nov. 2 , 19 59 , and that death occurred at 7 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald F. Bartley M.D.				ADDRESS (Street, city or town, state) 97. Hanson St. Easton		DATE SIGNED 11-2-59 Ind.	
PHYSICIAN'S NAME (Type) Donald F. Bartley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1959		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE NOV 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13007

CERTIFICATE OF DEATH

12996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>8mo 4da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E</u> Last <u>Hammond</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>13</u> Year <u>1959</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13 1885</u>			
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Mr Edwin F. Hammond</u>				14. MOTHER'S MAIDEN NAME <u>MARY BISHOP</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-36-0607</u>		17. INFORMANT <u>A. B. Hammond</u> Address <u>Brother Queenstown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach c</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized carcinomatosis</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>6 months +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> 19 <u>59</u> , to <u>11/13</u> 19 <u>59</u> , that I last saw the deceased alive on <u>11/13/59</u> , 19 <u>59</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Wm. D. Noble</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Md</u> DATE SIGNED <u>11/16/59</u>					
PHYSICIAN'S NAME (Type) <u>WILLIAM D NOBLE</u>				<u>EASTON MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestersfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Suter Jr. of Baltimore</u> ADDRESS <u>Centerville Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>			

CERTIFICATE OF DEATH

13007

13006

MAITLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

For Use By

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH (To be filled in by the physician or other qualified person)

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH (To be filled in by the physician or other qualified person)

DATE OF BIRTH

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MAITLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED
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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12997

13008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>West St. Mem Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Alexander Harris</u>		4. DATE OF DEATH <u>November 19 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 18, 1959</u>
9. AGE (In years last birthday) <u>3 years</u>		IF UNDER 1 YEAR <u>3</u> Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Harris</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Elizabeth McDaniel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral Pneumonia</u> <u>492x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Kenneth W. Welch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELCH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-19-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. DeChiel</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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13003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13003

Form with multiple sections for medical examination, including fields for name, age, sex, occupation, and cause of death. The form is partially filled out with handwritten text.

NAME: [Handwritten Name]
AGE: [Handwritten Age]
SEX: [Handwritten Sex]
OCCUPATION: [Handwritten Occupation]
CAUSE OF DEATH: [Handwritten Cause of Death]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12998

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FEDERALSBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		d. STREET ADDRESS R.F.D. #1, BOX 75	
3. NAME OF DECEASED (Type or print) First ANNA Middle GERTRUDE Last HAYNES		4. DATE OF DEATH Month NOVEMBER Day 4 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1901 JULY 5, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE (In years last birthday) 58 yrs.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NUMBERS TRUXON		14. MOTHER'S MAIDEN NAME EMMA CAROLINE CO. STANFORD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT LOUISE HAYNES - DAUGHTER - SAME		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1959 to 1959 , that I last saw the deceased alive on Oct 29, 1959 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. H. Schmitt		DATE SIGNED 219 S. Westminister St. 5th Nov 59	
PHYSICIAN'S NAME (Type) E. C. H. Schmitt		ADDRESS (Street, city or town, state) Easton 16, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Saint Paul Cemetery	22d. LOCATION (City, town, or county) (State) Near Federalsburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton Son		ADDRESS Federalsburg Md.	
24a. REC'D BY REGISTRAR NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12999

13010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If deceased had no usual residence before admission) a. STATE Maryland b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wye Mills, Md.	
c. LENGTH OF STAY IN 1b 3 hrs 10 min		d. STREET ADDRESS HUMPHREYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ORA Middle May Last Humphreys		4. DATE OF DEATH Month Nov Day 3 Year 1959	
5. SEX Fe.	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 29, 1914
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Nellie Grover	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT MRS. ORA May Gibson daughter, same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASC. HEMORRHAGE DUE TO 443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) HYPERTENSIVE CARDIO-VASC. DISEASE DUE TO YEARS (c)		INTERVAL BETWEEN ONSET AND DEATH 9 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-3- , 19 59 , to 11-3- , 19 59 , that I last saw the deceased alive on 11-3- , 19 59 , and that death occurred at 7:20 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald F. Bartley M.D.		DATE SIGNED 11-3-59	
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY		ADDRESS (Street, city or town, state) 9 N. Hanson St. Easton, Md.	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Nov. 5, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem.	22d. LOCATION (City, town, or county) (State) Cabot Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE A. Q. Harkness & Son - Funeral, Inc.		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 5 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

CERTIFICATE OF DEATH

13010

Page No. 10

PLACE OF DEATH		MARRIAGE	
1. PLACE OF DEATH		2. DATE OF MARRIAGE	
3. NAME OF DECEASED		4. NAME OF DECEASED	
5. SEX		6. AGE	
7. RACE		8. OCCUPATION	
9. CAUSE OF DEATH		10. PLACE OF BIRTH	
11. DATE OF DEATH		12. TIME OF DEATH	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED	
39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED	
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49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED	
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57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
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63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED	
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81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED	
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89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13000

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ST. MICHAELS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BUENAVISTA NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle KIMMEY Last KIMMEY		4. DATE OF DEATH Month NOV Day 1 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 1, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN D. GEORGE		14. MOTHER'S MAIDEN NAME MARTHA CARROLL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT EMORY KIMMEY		Address DENTON, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Cerebral artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to (c) Due to			INTERVAL BETWEEN ONSET AND DEATH 3
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 0 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1 Sept , 19 59 to 1 Nov , 19 59 , that I last saw the deceased alive on 30 Oct , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DENTON, MD DATE SIGNED 3 Nov 59 ACTUAL SIGNATURE Thurston Harrison M.D. Arthur S. Kraus PHYSICIAN'S NAME (Type) THURSTON HARRISON			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	NOV 4, 1959	DENTON	DENTON, MD
23. FUNERAL DIRECTOR'S SIGNATURE Wingard Moore		24a. REC'D BY REGISTRAR DATE NOV 9 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

13011

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13001

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>		d. STREET ADDRESS <u>05 X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>W</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>November</u> Day <u>20</u> Year <u>19 59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 9, 1929</u>	
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Richard Derricott</u>				14. MOTHER'S MAIDEN NAME <u>Willie Jane Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>				16. SOCIAL SECURITY NO. <u>163X</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>163X</u> DUE TO (c) <u>163X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>163X</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>> 3 mos.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct. 19</u> , 19 <u>59</u> , to <u>Nov 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>59</u> , and that death occurred at <u>7:58 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u>11-23-59</u>							
ACTUAL SIGNATURE <u>Robert W. Trever</u>				M.D. <u>202 Dover St.</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER M.D.</u>				<u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>NOV 30 1959</u>		22b. DATE THEREOF <u>NOV 30 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hamilton Harrison, Jr. Michael</u>				ADDRESS <u>md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>							

10

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13002

13012

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mc Daniel</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary G. Lowe</u>	4. DATE OF DEATH Month <u>Nov</u> Day <u>7</u> Year <u>19 59</u>		
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u>5</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Lowe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Francis Wrighton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Carroll Lowe, brother</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Viral myocarditis</u> DUE TO (b) <u>2. Resolving viral pneumonitis</u> DUE TO (c) <u>3. Nephrosclerosis</u> DUE TO <u>4. Focal hemorrhagic encephalopathy</u> DUE TO <u>5. Focal fibrosis of the cerebro-arachnoid</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lewis P. Welch</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELCH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11-9-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Hambleton Harrison</u>		ADDRESS <u>St. Michaels</u>	
24a. REC'D BY REGISTRAR <u>NOV 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

5.05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13013

CERTIFICATE OF DEATH

13003

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>6 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				p. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Addie V. Martin</u>				4. DATE OF DEATH Month Day Year <u>November 7 1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 23, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Edwin Tyler</u>				14. MOTHER'S MAIDEN NAME <u>Rose Cummings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>EASTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2 Nov</u> , 19 <u>59</u> , to <u>7 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7 Nov</u> , 19 <u>59</u> , and that death occurred at <u>7:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston N Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Chesapeake Bay Ave</u> DATE SIGNED <u>9 Nov 59</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON N HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Buck</u> ADDRESS <u>5302 Harford Rd. Baltimore, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Hume</u>	

1

13014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville Rural #1</u>			
c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>				d. STREET ADDRESS <u>17X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Yvonne</u> Middle <u>Newton</u> Last <u>Newton</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 17 1929</u>	
9. AGE (In years last birthday) yrs. <u>19</u>		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Edward Newton</u>				14. MOTHER'S MAIDEN NAME <u>Grace R. Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>768.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia (overwhelming)</u> DUE TO (c) <u>2 da</u> <u>2 da</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11-5</u> , 19 <u>59</u> , to <u>11-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>59</u> , and that death occurred at <u>10:15</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>205 Earle Ave</u> DATE SIGNED <u>Easton, Maryland</u>							
ACTUAL SIGNATURE <u>John S. Raybitt</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Easton, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 8-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burial</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Centreville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barbara S. Brown</u> ADDRESS <u>2080 225XV4</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 13 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13015

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>30 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>RT#3</u>	
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Elmira</u> Last <u>PARSONS</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1945</u>
9. AGE (In years last birthday) <u>14</u> yrs.		IF UNDER 1 YEAR: Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Girl</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS RAYMOND XXX PARSONS</u>		14. MOTHER'S MAIDEN NAME <u>MAE Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Raymond T. Parsons (Father) R.D.# 3 Delmar, Maryland</u>	
17. INFORMANT <u>Mr. Raymond T. Parsons (Father) R.D.# 3 Delmar, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrosis</u> <u>591X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>219 S. Westminister ST. 29 Nov 59</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. <u>Easton 16, Maryland</u> PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 2, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13012

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
J. T. LAYTON		M		45		JAN 15 1890		BALTIMORE, MD.	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH	
MARRIED		JAN 15 1915		BALTIMORE, MD.		J. T. LAYTON		JAN 15 1915	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
LABORER		JAN 15 1935		BALTIMORE, MD.		HEART DISEASE		NATURAL	
EDUCATION		DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER	
HIGH SCHOOL		JAN 15 1935		BALTIMORE, MD.		J. T. LAYTON		J. T. LAYTON	
RELIGION		DATE OF BURIAL		PLACE OF BURIAL		NAME OF CEMETERY		NAME OF MINISTER	
METHODIST		JAN 15 1935		BALTIMORE, MD.		J. T. LAYTON		J. T. LAYTON	
DATE OF DEATH		DATE OF INTERMENT		DATE OF BURIAL		DATE OF CREMATION		DATE OF REINTERMENT	
JAN 15 1935		JAN 15 1935		JAN 15 1935					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13007

13016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>William Gilbert Poore, Sr.</i>		4. DATE OF DEATH Month Day Year <i>November 5 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26, 1897</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DISABLED VETERAN - U.S. Army</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Delaware</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Alfred Poore</i>		14. MOTHER'S MAIDEN NAME <i>Laura Choires</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give year or dates of service) <i>WW I</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>wife -</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 241X DUE TO <i>Cos Pulmonale</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO <i>Asthma</i> (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>3 years</i> <i>30+ years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4 November 59</i> to <i>5 Nov 59</i> , that I last saw the deceased alive on <i>5 Nov 59</i> , and that death occurred at <i>8:40 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>K. Lane Watts</i> M.D.		ADDRESS (Street, city or town, state) <i>Box 489, St. Michaels, Md</i> DATE SIGNED <i>11-6-59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 8, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bozman Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Bozman, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. Hamilton Harrison, St. Michaels, Md</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE <i>NOV 10 '59</i>			

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 22-B, Film G253 12/4/59 iwk

13029

CERTIFICATE OF DEATH

Reg. Dist. No.

13008

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>ELLEN</u> First <u>LOUISE</u> Middle <u>Roberts</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/18</u>		9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mae Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give branch and date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of right breast</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>59</u> , to <u>14 Nov</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12 Nov</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D.				ADDRESS (Street, city or town, state) <u>227 Pine St. Cambridge, Md.</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>11/18/1959</u>		<u>TRAPPE Cem</u>		<u>TRAPPE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Shook</u> ADDRESS <u>Boston, Md.</u>				24a. REC'D BY REGISTRAR <u>DA DEC 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

Item 8 Film G252 12-1-59 et

13009

13017

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newcomb</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Rigg</u> Last <u>Ross</u>				4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 19, 1895</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Adoni Ross</u>				14. MOTHER'S MAIDEN NAME <u>Norther A. Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-28-4706</u>		17. INFORMANT <u>McC. R. Ross</u> Address <u>Fluorcomb, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior - Myocardial Heart Disease</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>June</u> Day <u>19</u> Year <u>1955</u> Hour <u>a. m.</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JUNE 1955</u> to <u>NOV. 23, 1959</u> , that I last saw the deceased alive on <u>NOV. 23, 1959</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald F. Bartley</u>				ADDRESS (Street, city or town, state) <u>9 N. HANSON ST. EASTON, MD.</u>			
DATE SIGNED <u>11-23-59</u>							
PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>No. 27, 59</u>		22b. DATE THEREOF <u>Nov. 27, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Galt</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Hines</u>	

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>RF#2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Saathoff</u> Last <u>Saathoff</u>				4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 10, 1897</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Saathoff</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Saathoff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Lillian Jenkins Saathoff R-2 Easton Md</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.1</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>50</u> , to <u>6 Nov</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6 Nov</u> 19 <u>59</u> , and that death occurred at <u>5:25 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D. <u> </u>				DATE SIGNED <u>6 Nov 59</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>Aug 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woods Memorial</u>		22d. LOCATION (City, town, or county) <u>W-50-Easton Md</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

21031

13030

CERTIFICATE OF DEATH

Reg. Dist. No.

13011

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cordova</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cordova</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		/ d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Ola Middle (Sara) Last James</u>		4. DATE OF DEATH <u>Nov. 6</u> 19 <u>59</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur John Dean</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jane Bowser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-34-3015</u>	
17. INFORMANT <u>Mrs.ashed Rubin</u>		Address <u>Cordova</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stenotic Heart Disease.</u> (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 56</u> , 19 <u>56</u> , to <u>Nov. 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 4</u> , 19 <u>59</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Winnacott</u> M.D.		ADDRESS (Street, city or town, state) <u>RIDGELEY, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES H. WINNACOTT</u>		DATE SIGNED <u>RIDGELEY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>No. 8 59</u>		22b. DATE THEREOF <u>Nov. 8 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rollin Cook</u> ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

CERTIFICATE OF DEATH

1930

<p>1. Name of deceased: <i>John A. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 15, 1875</i></p>		<p>4. Age: <i>55</i></p>	
<p>5. Place of birth: <i>Sweden</i></p>		<p>6. Date of death: <i>Dec 10, 1930</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>Dr. J. H. Smith</i></p>		<p>10. Signature of registrar: <i>John A. Smith</i></p>	
<p>11. Signature of informant: <i>John A. Smith</i></p>		<p>12. Signature of witness: <i>John A. Smith</i></p>	
<p>13. Signature of undertaker: <i>John A. Smith</i></p>		<p>14. Signature of funeral home: <i>John A. Smith</i></p>	
<p>15. Signature of cemetery: <i>John A. Smith</i></p>		<p>16. Signature of burial place: <i>John A. Smith</i></p>	
<p>17. Signature of interment: <i>John A. Smith</i></p>		<p>18. Signature of final disposition: <i>John A. Smith</i></p>	
<p>19. Signature of final disposition: <i>John A. Smith</i></p>		<p>20. Signature of final disposition: <i>John A. Smith</i></p>	
<p>21. Signature of final disposition: <i>John A. Smith</i></p>		<p>22. Signature of final disposition: <i>John A. Smith</i></p>	
<p>23. Signature of final disposition: <i>John A. Smith</i></p>		<p>24. Signature of final disposition: <i>John A. Smith</i></p>	
<p>25. Signature of final disposition: <i>John A. Smith</i></p>		<p>26. Signature of final disposition: <i>John A. Smith</i></p>	
<p>27. Signature of final disposition: <i>John A. Smith</i></p>		<p>28. Signature of final disposition: <i>John A. Smith</i></p>	
<p>29. Signature of final disposition: <i>John A. Smith</i></p>		<p>30. Signature of final disposition: <i>John A. Smith</i></p>	
<p>31. Signature of final disposition: <i>John A. Smith</i></p>		<p>32. Signature of final disposition: <i>John A. Smith</i></p>	
<p>33. Signature of final disposition: <i>John A. Smith</i></p>		<p>34. Signature of final disposition: <i>John A. Smith</i></p>	
<p>35. Signature of final disposition: <i>John A. Smith</i></p>		<p>36. Signature of final disposition: <i>John A. Smith</i></p>	
<p>37. Signature of final disposition: <i>John A. Smith</i></p>		<p>38. Signature of final disposition: <i>John A. Smith</i></p>	
<p>39. Signature of final disposition: <i>John A. Smith</i></p>		<p>40. Signature of final disposition: <i>John A. Smith</i></p>	
<p>41. Signature of final disposition: <i>John A. Smith</i></p>		<p>42. Signature of final disposition: <i>John A. Smith</i></p>	
<p>43. Signature of final disposition: <i>John A. Smith</i></p>		<p>44. Signature of final disposition: <i>John A. Smith</i></p>	
<p>45. Signature of final disposition: <i>John A. Smith</i></p>		<p>46. Signature of final disposition: <i>John A. Smith</i></p>	
<p>47. Signature of final disposition: <i>John A. Smith</i></p>		<p>48. Signature of final disposition: <i>John A. Smith</i></p>	
<p>49. Signature of final disposition: <i>John A. Smith</i></p>		<p>50. Signature of final disposition: <i>John A. Smith</i></p>	
<p>51. Signature of final disposition: <i>John A. Smith</i></p>		<p>52. Signature of final disposition: <i>John A. Smith</i></p>	
<p>53. Signature of final disposition: <i>John A. Smith</i></p>		<p>54. Signature of final disposition: <i>John A. Smith</i></p>	
<p>55. Signature of final disposition: <i>John A. Smith</i></p>		<p>56. Signature of final disposition: <i>John A. Smith</i></p>	
<p>57. Signature of final disposition: <i>John A. Smith</i></p>		<p>58. Signature of final disposition: <i>John A. Smith</i></p>	
<p>59. Signature of final disposition: <i>John A. Smith</i></p>		<p>60. Signature of final disposition: <i>John A. Smith</i></p>	
<p>61. Signature of final disposition: <i>John A. Smith</i></p>		<p>62. Signature of final disposition: <i>John A. Smith</i></p>	
<p>63. Signature of final disposition: <i>John A. Smith</i></p>		<p>64. Signature of final disposition: <i>John A. Smith</i></p>	
<p>65. Signature of final disposition: <i>John A. Smith</i></p>		<p>66. Signature of final disposition: <i>John A. Smith</i></p>	
<p>67. Signature of final disposition: <i>John A. Smith</i></p>		<p>68. Signature of final disposition: <i>John A. Smith</i></p>	
<p>69. Signature of final disposition: <i>John A. Smith</i></p>		<p>70. Signature of final disposition: <i>John A. Smith</i></p>	
<p>71. Signature of final disposition: <i>John A. Smith</i></p>		<p>72. Signature of final disposition: <i>John A. Smith</i></p>	
<p>73. Signature of final disposition: <i>John A. Smith</i></p>		<p>74. Signature of final disposition: <i>John A. Smith</i></p>	
<p>75. Signature of final disposition: <i>John A. Smith</i></p>		<p>76. Signature of final disposition: <i>John A. Smith</i></p>	
<p>77. Signature of final disposition: <i>John A. Smith</i></p>		<p>78. Signature of final disposition: <i>John A. Smith</i></p>	
<p>79. Signature of final disposition: <i>John A. Smith</i></p>		<p>80. Signature of final disposition: <i>John A. Smith</i></p>	
<p>81. Signature of final disposition: <i>John A. Smith</i></p>		<p>82. Signature of final disposition: <i>John A. Smith</i></p>	
<p>83. Signature of final disposition: <i>John A. Smith</i></p>		<p>84. Signature of final disposition: <i>John A. Smith</i></p>	
<p>85. Signature of final disposition: <i>John A. Smith</i></p>		<p>86. Signature of final disposition: <i>John A. Smith</i></p>	
<p>87. Signature of final disposition: <i>John A. Smith</i></p>		<p>88. Signature of final disposition: <i>John A. Smith</i></p>	
<p>89. Signature of final disposition: <i>John A. Smith</i></p>		<p>90. Signature of final disposition: <i>John A. Smith</i></p>	
<p>91. Signature of final disposition: <i>John A. Smith</i></p>		<p>92. Signature of final disposition: <i>John A. Smith</i></p>	
<p>93. Signature of final disposition: <i>John A. Smith</i></p>		<p>94. Signature of final disposition: <i>John A. Smith</i></p>	
<p>95. Signature of final disposition: <i>John A. Smith</i></p>		<p>96. Signature of final disposition: <i>John A. Smith</i></p>	
<p>97. Signature of final disposition: <i>John A. Smith</i></p>		<p>98. Signature of final disposition: <i>John A. Smith</i></p>	
<p>99. Signature of final disposition: <i>John A. Smith</i></p>		<p>100. Signature of final disposition: <i>John A. Smith</i></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13019

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13012

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> 05X-2	
c. LENGTH OF STAY IN 1b <u>4 hrs. - 12 mins.</u>		d. STREET ADDRESS <u>NICHOLS ROAD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Norris DICKERSON, Scott</u>		4. DATE OF DEATH <u>November 30 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 28, 1923</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAROLINE POULTRY FARMS, INC.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Emmanuel Scott</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle Dickerson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>Unknown No</u>		16. SOCIAL SECURITY NO. <u>220-03-3526</u>	
17. INFORMANT <u>MRS. IOLA OWENS, WILMINGTON, DELAWARE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive</u> (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 h.</u> ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lawson D. George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAWSON D. George</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11-30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 5, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FEDERAL HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton & Son, Federalburg, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Charles E. House</u>	

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13031
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

13013

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle SEWALL Last SMITH		4. DATE OF DEATH Month November Day 4 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1866
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Brookline, Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME I. S. Getchell		14. MOTHER'S MAIDEN NAME Morgiana Sewall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Eleanor F. S. Kerr, S. J. Michaels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus DUE TO 693.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cellulitis of left leg. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis		INTERVAL BETWEEN ONSET AND DEATH 30 min. 48 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3:40 to 4:40 , 19 59 , that I last saw the deceased alive on 4:40 , 19 59 , and that death occurred at 3:50 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Lane Wroth M.D.		ADDRESS (Street, city or town, state) Box 489, St. Michaels, Md 511059	
DATE SIGNED			
PHYSICIAN'S NAME (Type) R. LANE WROTH, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 6, 1959	
22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hampton Harrison, St Michaels		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 14175

13020

1. PLACE OF DEATH a. COUNTY TALBOTT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 3 CENTREVILLE RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, EASTON		e. STREET ADDRESS Rt. #3 17X-2	
3. NAME OF DECEASED (Type or print) First GEORGE Middle STANFORD Last STANFORD		4. DATE OF DEATH Month NOVEMBER Day 29 Year 1959	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/1885
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVALID		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE STANFORD		14. MOTHER'S MAIDEN NAME SARAH SUTTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT WIFE - EMMA STANFORD		Address Rt. 3 CENTREVILLE MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY AND GENERALIZED DUE TO (c) ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 10 YEARS +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/28/1959 , to 11/29/1959 , that I last saw the deceased alive on 11/29/1959 , and that death occurred at 12:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Kent Young		ADDRESS (Street, city or town, state) 105 Chesterfield Ave. Centreville Md.	
M.D. J. KENT YOUNG		DATE SIGNED DEC 1 0 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/59	
22c. NAME OF CEMETERY OR CREMATORY New Dawn Cem		22d. LOCATION (City, town, or county) (State) Centreville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Cashfield Easton Inc.		24. REC'D BY REGISTRAR DATE DEC 1 0 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 22 & 1 Film G255 12/3/59 iwk
13032
CERTIFICATE OF DEATH

13014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HOWARD</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROYAL OAK home of daughter</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLIOTT CITY - 13X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Mrs. Scott Kilmon, daughter)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Strohmmer</u>		4. DATE OF DEATH <u>11-23-59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY-9-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U</u>	
13. FATHER'S NAME <u>LORY</u>		14. MOTHER'S MAIDEN NAME <u>FLORA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>M. J. Jos G. STROMMER</u>		Address <u>6002 Pinehurst Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cachexia - more generalized</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>adenocarcinomatosis - generalized</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cardiac failure - chronic. A.C.V.D.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-28-55</u> , to <u>11-23-59</u> , that I last saw the deceased alive on <u>11-23-59</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Guy M. Reeser Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>St Michaels MD</u>	
DATE SIGNED <u>11-23-59</u>			
PHYSICIAN'S NAME (Type) <u>Guy M. Reeser Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 27, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Belair Rd Belts MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>THOMAS J KENNY INC</u>		ADDRESS <u>1600 Hollins St</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

13021

CERTIFICATE OF DEATH

Reg. Dist. No.

13015

1. PLACE OF DEATH a. COUNTY TALBOTT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE DELAWARE b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 1 1/4 hours			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILMINGTON				8 46 x .3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, EASTON				d. STREET ADDRESS 2402 NEWPORT GAP AVE THE CEDARS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HELEN Middle E. Last TAYLOR				4. DATE OF DEATH Month NOVEMBER Day 30 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 29, 1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM TAYLOR				14. MOTHER'S MAIDEN NAME SARAH ELIZABETH HOUSTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 162-28-18		17. INFORMANT Address MRS. MARY BRISTOW, 210 WASHINGTON AVE. WILMINGTON, DEL.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c) YEARS				INTERVAL BETWEEN ONSET AND DEATH 3 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 11/30/1959 , to 11/30/1959 , that I last saw the deceased alive on 11/30/1959 , and that death occurred at 2:15 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Kent Young		M.D.		ADDRESS (Street, city or town, state) 105 Chestersfield Ave. Centerville Maryland		DATE SIGNED	
PHYSICIAN'S NAME (Type) J. KENT YOUNG							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/3/59	22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		22d. LOCATION (City, town, or county, state) Oxford Chester Co. Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson Rising Sun Md				24. REC'D BY REGISTRAR DATE DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G257 2-26-60 et

13016

13022

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Saltat</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Manford</u> b. COUNTY <u>Saltat</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>125 S. Hanover St.</u>				d. STREET ADDRESS <u>125 S. Hanover St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Hendrick Twitley</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1883</u>	
9. AGE (In years last birthday) yrs. <u>76</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTH PLACE (State or foreign country) <u>South Carolina</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Salesman</u>		11. BIRTH PLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Twitley</u>				14. MOTHER'S MAIDEN NAME <u>Josephine R. Compton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-03-7521</u>		17. INFORMANT <u>Ther Mildred Price Twitley</u>		Address <u>125 S. Hanover St. Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1st CVD</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19 <u>56</u> , to <u>11/8/59</u> , 19 <u>59</u> that I last saw the deceased alive on <u>11/8/59</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>P. E. Cox</u>				M.D. <u>Easton Md</u>			
PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov. 10, 59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knave</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knave</u>	

CERTIFICATE OF DEATH

10023

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1950</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. PHYSICIAN'S SIGNATURE <i>Dr. J. Smith</i>		17. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		18. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
19. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		20. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		21. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
22. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		23. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		24. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
25. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		26. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		27. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
28. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		29. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		30. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
31. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		32. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		33. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
34. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		35. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		36. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
37. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		38. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		39. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
40. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		41. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		42. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
43. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		44. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		45. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
46. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		47. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		48. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
49. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		50. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		51. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
52. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		53. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		54. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
55. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		56. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		57. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
58. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		59. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		60. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
61. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		62. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		63. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
64. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		65. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		66. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
67. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		68. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		69. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
70. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		71. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		72. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
73. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		74. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		75. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
76. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		77. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		78. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
79. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		80. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		81. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
82. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		83. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		84. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
85. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		86. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		87. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
88. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		89. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		90. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
91. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		92. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		93. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
94. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		95. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		96. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
97. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		98. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		99. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
100. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		101. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		102. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
103. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		104. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		105. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
106. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		107. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		108. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
109. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		110. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		111. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
112. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		113. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		114. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
115. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		116. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		117. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
118. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		119. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		120. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
121. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		122. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		123. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
124. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		125. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		126. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
127. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		128. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		129. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
130. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		131. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		132. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
133. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		134. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		135. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
136. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		137. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		138. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	
139. COUNTY HEALTH OFFICER'S NAME <i>John Doe</i>		140. CITY HEALTH OFFICER'S NAME <i>John Doe</i>		141. COUNTY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>	
142. CITY HEALTH OFFICER'S ADDRESS <i>123 Main St.</i>		143. COUNTY HEALTH OFFICER'S PHONE <i>123-4567</i>		144. CITY HEALTH OFFICER'S PHONE <i>123-4567</i>	
145. COUNTY HEALTH OFFICER'S TITLE <i>Health Officer</i>		146. CITY HEALTH OFFICER'S TITLE <i>Health Officer</i>		147. COUNTY HEALTH OFFICER'S EXPIRATION <i>1951</i>	
148. CITY HEALTH OFFICER'S EXPIRATION <i>1951</i>		149. COUNTY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>		150. CITY HEALTH OFFICER'S SIGNATURE <i>John Doe</i>	

RECEIVED
JAN 15 1950
BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13023

CERTIFICATE OF DEATH

13017

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Albot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>3da</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>NONE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Judith Lynn Ward</u>				4. DATE OF DEATH Month Day Year <u>11 18 1959</u>			
5. SEX <u>fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-59</u>	
9. AGE (In years lost birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>3</u>		IF UNDER 24 HRS. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>DAVID CAREY WARD</u>				14. MOTHER'S MAIDEN NAME <u>Joyce ANN Nichols</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> <u>773.5</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>59</u> , to <u>11/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/18</u> , 19 <u>59</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>205 Earle Ave, Easton</u> DATE SIGNED <u>11/20/59</u> ACTUAL SIGNATURE <u>Barbara Williams MD</u> M.D. <u>205 Earle Ave, Easton</u> PHYSICIAN'S NAME (Type) <u>Barbara Williams</u> M.D. <u>205 Earle Ave, Easton, Md.</u> <u>11/20/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-19-59</u>		<u>Greensboro</u>		<u>Greensboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaie's</u> ADDRESS <u>Greensboro Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

2080212XV3

13024

CERTIFICATE OF DEATH

Reg. Dist. No. 13018

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 E. Darnall St.</u>				d. STREET ADDRESS <u>207 E. Darnall St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Josephine Willis</u>				4. DATE OF DEATH Month Day Year <u>Nov. 29 1959</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 16 1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Talbot, Prince Georges</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Flynn</u>				14. MOTHER'S MAIDEN NAME <u>Riley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>William Willis</u>		Address <u>Easton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the colon</u> DUE TO (c) <u>(?)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1950</u> , to <u>29 Nov 1959</u> , that I last saw the deceased alive on <u>26 Nov 59</u> , 19 <u>59</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>20 Nov 59</u>							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Dec 29 59</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Black</u> ADDRESS <u>Easton Md</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13019

13033

Item 7 Film G252 12-1-59 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RTD GELY 05X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First JOHN Middle G Last WILSON		4. DATE OF DEATH Month NOV Day 20 Year 1959	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 26, 1915
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL		10b. KIND OF BUSINESS OR INDUSTRY CAROLINE CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME NORMAN WILSON		14. MOTHER'S MAIDEN NAME SARA ELMA DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT James Wilson		Address Ridgely, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PARTIAL DECAPITATION 823X DUE TO AUTO ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AUTO ACCIDENT DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DRIVER OF CAR LEFT ROAD JUMPED STREAM CRASHED	
20c. TIME OF INJURY Month, Day, Year 6:43 P.M. NOV 20 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HI WAY	20f. (City or town) (County) (State) NR EASTON TALBOT MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WELTY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Virgil Moore & Son		ADDRESS Yorkton, Md	
24a. REC'D BY REGISTRAR NOV 25 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

